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RAISED BILLS 454 AND 455

My husband, Joseph (Joe) E. Sullivan was a resident at the Connecticut Veterans' Hospital in Rocky Hill from February 2006 to August 2007. Joe had a diagnosis of severe dementia. Joe was non-verbal.

Raised Bill 455: An Act Concerning the Nursing Home Bill of Rights

February 2006 Joe was on the Special Care Unit as a respite client when a long-term bed became available and he became a permanent resident. I was not given a Patient Bill of Rights.

July 6, 2007 Joe went into respiratory crisis. He was transferred to the Respiratory Unit. Staff attending him on this unit did not demonstrate dementia knowledge.

- 1) When I offered information about Joe, the reply was, "I/we have his chart". Joe was not a chart.
- 2) I was not considered an integral member of Joe's care team. My requests for information and notification of treatment were ignored.

July 29, 2007 Joe was left in the day room. He had a coagulated blood skin tear on his hand. Son, Mark, requested it be attended to.

July 31, 2007 Ann Kelly, PT and I, separately, alerted staff to a change in Joe's behavior. Our concerns were not addressed.

Raised Bill 454: An Act Concerning Nursing Home Staffing Levels

July 6 to August 20, 2007 Joe was tended to by men and women who may/may not have been credentialed.

August 3, 2007 I was notified Joe would be taken for an X-ray of his right hip. Joe's right hip was fractured.

Joe was transferred to St. Francis Hospital for evaluation. From St. Francis I spoke, by phone, with Margaret Pantoja, Assistant Hospital Administrator. I updated her on Joe's health status. I asked her if I should be talking with a discharge planner. Ms. Pantoja assured me, "Mr. Sullivan can be cared for anywhere in the hospital". I said, "hospice".

Joe did not go to the Hospice Unit. He was returned to the Respiratory Unit. The same place he had his right hip fractured and cared for by staffs who were not only oblivious to his quality-of-life and end-of-life needs but did not tell me they were incapable of providing it.

A report from St. Francis Hospital and UCONN Health Care stated Joe's right hip was fractured 1 - 2 weeks prior to determination.

August 6, 2007 I spoke with Flora Drapeau, APRN, Special Care Unit. I demanded Joe be transferred to the Hospice Unit. Ms. Drapeau arranged for me to speak with Deb Sutherland, APRN, Palliative/Hospice Unit. Joe was transferred to the Hospice Unit.

Unfortunately, staff was not hospice certified.

When Joe entered the Connecticut Veterans Hospital:

- 1) I was not given a Patient Bill of Rights
- 2) I was not told Joe may not age-in-place
- 3) I was not told the facility lacked accreditation
- 4) I was not told staff may not be dementia and hospice credentialed
- 5) I was not told Joe would be denied the Medicare benefit of hospice

August 20, 2007 Joe passed into eternal peace.

Before Joe's death, and since, I have been requesting information about his care from staff at the Connecticut Veterans' Hospital. It has not been forthcoming.

For the period July 6 – August 20, 2007 I specifically asked for:

- 1) the identity of person(s) who determined Joe would be transferred from St. Francis to the Respiratory Unit instead of either the Special Care Unit or the Hospice Unit as I requested
- 2) the patient-staff ratio, all shifts, for the Respiratory and Hospice Units
- 3) the names and credential(s) of all staff who provided direct care and hands-on care; including veteran workers and/or volunteers

Joe did not get care that was appropriate and best for him.
Joe got care that was convenient for staff.

I am asking you to require every resident and/or advocate:

- 1) receive a Patient Bill of Rights
- 2) be included in every health care and quality-of-life decision; technology allows for constant/continuous communication
- 3) learn the names and credential(s) of all who provide direct/hands-on care
- 4) learn the daily patient to staff ratios
- 5) apply the same rules for state facilities that apply to profit and not-for-profit facilities
- 6) increase inspections of all Connecticut facilities
- 7) increase the number of RN, LPN and CNA hours per resident care; mindful that residents' need(s) may require accommodation as health status changes
- 8) provide residents' and/or advocates facility healthcare rating

It is not enough to have a facility promoted for type of care offered, the facility staff must be held accountable for providing appropriate and best care practices.

Enc.

Connecticut Cancer Partnership 2006, page 10

Home for the Heroes, Official Newsletter of the Connecticut Veterans' Home at Rocky Hill, May 2007 issue, "Serving Those Who Served...", page 6

Alzheimer's Association, Connecticut Chapter Newsletter, Winter 2007, column: In Safe Hands, "The Scourge of Elder Abuse" pages 10 and 11

PALLIATIVE AND HOSPICE CARE

Background

Few people are ready to make the hard choices that are needed at the end of life. However, palliative and hospice care offer the best quality of life during the time that remains, by addressing physical, emotional, social, and spiritual needs. They can ease the pain and improve life for those who are dying of cancer, and for their families and friends. Palliative care relieves pain and suffering but does not treat or cure disease. Hospice care is a program of palliative care and support services for both people who are dying and their families.

Connecticut is home to the nation's first inpatient hospice, and several organizations have begun working to improve palliative and hospice care. The availability and use of end-of-life care in Connecticut was surveyed in 2000, and strengths and challenges were identified. This information needs to be updated, and the use of services by underserved populations needs to be measured.

Many patients don't know they have options for end-of-life care and thus don't ask for them. Others do not receive adequate palliative and hospice care services, even when the services are requested. This is the result of several factors. First, the kind, quality, and amount of care received depend on where the patients reside (at home, long-term care or assisted-living facilities, hospitals, or prisons). Second, health care professionals often are not well trained in palliative or hospice care. Third, there are cost issues: Medicare and some insurance plans cover hospice care, but palliative care is often covered indirectly, if at all. In addition, cultural backgrounds, religious beliefs, income, and education can affect both the use and delivery of palliative and hospice care.

Highlights of the information considered by the Palliative and Hospice Care Committee when it formulated priorities are:

- In 2000, only one quarter of one percent of primary care and primary care subspecialty physicians and half of one percent of full-time registered nurses in Connecticut were certified in palliative care.
- Connecticut residents would like better communications with providers about death and dying, more prompt referrals to hospice and palliative care, better coordination of care, more counseling to dying patients, and more access to spiritual care.

Palliative and hospice care offer the best quality of life during the time that remains, by addressing physical, emotional, social, and spiritual needs.

- Racial, ethnic, and religious groups would like providers to have a better understanding of the cultural context (e.g., diet, language, and religion) of their patients. Minorities may be less informed about services due to language or cultural barriers.
- Low-income and medically underserved populations may have less access to palliative and hospice care services.
- Of Connecticut hospitals, only 33% self-report palliative care programs and 58% report hospice programs. Few hospice and palliative care services are available to residents of prisons and long-term care facilities.

Priorities for Palliative & Hospice Care in Connecticut Access and Availability

- Increase the number of health care professionals (physicians, nurses, social workers, and spiritual counselors) who are knowledgeable about palliative and hospice care
- Increase the number of health professionals who are board certified in palliative and hospice care
- Increase the number of health insurance programs that provide coverage for pain and palliative/hospice services
- Increase the proportion of facilities with palliative care programs
- Increase the number of hospitals and long-term care facilities that have contractual agreements with Medicare-certified hospice programs
- Improve end-of-life care in Connecticut State correctional facilities
- Improve end-of-life care services in the State Veterans Home
- Assess patient and family satisfaction with palliative and hospice services

Quality of Life

- Increase legislation and public policy supporting pain, palliative, and hospice care services
- Decrease the prevalence of pain among Connecticut nursing home residents
- Increase patient and family satisfaction with management of pain and symptoms

Awareness of, Preparation for, and Willingness to Seek Care

- Increase utilization of palliative and hospice care
- Increase the number of referrals to hospice and palliative care, especially among persons from minority and medically underserved populations

Serving Those Who Served...

By Margaret Concannon, M.Ed., NHA, CTRS,
Healthcare Services Administrator

It is an honor for us at the State Veterans' Home to serve the healthcare needs of those who served our nation. Our dedicated staff of nearly 160 staff members on three shifts care for the veterans by providing medical, nursing, rehabilitation therapy and recreation to 125 veterans in the chronic disease and long term healthcare facility and 380 residents in the domiciliary and veterans recovery program. Our colleagues include two Physicians, four Nurse Practitioners, around the clock nursing provided by registered nurses and nursing assistants, rehabilitation therapists, social workers, pharmacy, dietitians, laboratory technicians, and many other support staff. The Veterans' Recovery Program provides education, motivation and environmental support for veterans seeking recovery from the effects of substance abuse. We have a clinical psychologist and four Substance Abuse counselors assigned to this program and we are supported by a comprehensive Mental Health team consisting of two full time psychiatric nurse practitioners and part-time psychiatrist on staff from the Federal VA. The best results happen as we all work together to establish a comprehensive care plan that emphasizes collaborative relationships with the veterans, the families, and each of the healthcare professionals.

We integrate medical, health, wellness, recreation, rehabilitation, and social support to enhance our veteran's quality of life. By working closely with the Federal VA we coordinate the medical and health related services of our veterans which results in better health outcomes and continuity of care for our veterans. The Healthcare Facility treats veterans with chronic illnesses such as stroke, Parkinson's disease, pulmonary disease, and cancer. The Healthcare Facility which is equipped with its own pharmacy, radiology and dental departments also provides a variety of services such as podiatry, optometry and mental health support.

The DVA offers Hospice and Palliative care, a specialized Alzheimer's Care unit, Respiratory Care unit, and Respite Care Program. Our residents, depending on the nature and seriousness of their medical



needs, are treated in the Healthcare Facility by our staff or at area hospitals. Times are changing for us, too. Not long ago most of our residents were World War II veterans, but today we are proud to serve an increasing number of Vietnam veterans in need of chronic care.

It was a grand day when we broke ground for the new, state of the art, 125-bed Healthcare Facility to be completed in January, 2008. The new facility will offer all the same services we now provide, but will also have up to date rehabilitation facilities for veterans to actively participate in physical and occupational therapy. It will boast

a huge "family friendly" dining room with a fieldstone fireplace overlooking the Glastonbury hills and a large recreation room complete with aquarium, game tables, comfortable furniture, and movie screen for ongoing entertainment and enjoyment. The staff here are all anticipating this wonderful new facility, knowing that the quality, dedication and workmanship that we see going into our new home will improve the lives of our deserving Veterans.



Many family members send letters, praising the staff for the treatment, service and kindness they displayed in caring for their loved one here. They are living proof of our Home's motto, "Serving those who served."



In Safe Hands

In Safe Hands is a column which will address various safety issues for loved ones with dementia and their families as well as provide information for everyone as they prepare for aging.

The Scourge of Elder Abuse

by Denise Talbot, MA, Family Services Coordinator

In Safe Hands is a column which will address various safety issues for loved ones with dementia and their families as well as provide information for everyone as they prepare for aging.

The past two columns of In Safe Hands explored the potential physical dangers in the home and discussed how families can help make the environment friendlier for a loved one with dementia. This column's focus will be on the increasing problem of elder abuse.

What is elder abuse?

The National Center on Elder Abuse defines the term as "...any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult."

There are six types of abuse:

1. Physical Abuse - Causing pain or injury to an elder or threatening to do so. Withholding basic needs is also considered physical abuse.
2. Emotional Abuse - Causing anguish, anxiety, distress or mental pain, either through verbal or nonverbal communication.
3. Sexual Abuse - Sexual contact of any type which is non-consensual.
4. Neglect - Withholding or failing to provide food, shelter, health care or any other type of protection. Self neglect is also considered abuse.
5. Exploitation (financial or material) - Stealing, misappropriating or hiding money, property or other assets.
6. Abandonment - Desertion of the elder by a caregiver.

Cases of elder abuse are increasing, according to reports from studies and journals, but national numbers cannot

be reported because no system exists to track data. Elder abuse still largely remains a hidden problem.

The National Center on Elder Abuse, a non-profit organization, cited a report from the National Elder Abuse Incidence Study which found that in 1996 500,000 or more Americans aged 60 and older were domestic violence victims. The Senate Special Committee on Aging estimated that 5 million elders may be abuse victims.

Elder abuse, like Alzheimer's disease, does not discriminate. Both men and women from different social strata and ethnicities are affected.

There are at least four factors which may make an elder vulnerable to abuse. These are social isolation, cognitive impairment, i.e., Alzheimer's disease or another type of dementia, living with someone else, or a previous history of domestic violence.

What are some signs of abuse?

Physical

- Black and blue marks, internal bleeding, welts, lacerations, or rope burns.
- Bone fractures.
- Open wounds or injuries which have been left untreated.
- Dislocations or sprains.
- Broken eyeglasses or assistive devices.
- Misuse of prescription drugs - overdose or under utilization.
- A change in the behavior of the elder or their own report of physical abuse.
- Isolation of the elder by the caregiver.

Emotional Abuse

- Upset or agitated behavior.
- Non communicative or non responsive behavior; extreme withdrawal.
- Behavior such as sucking, biting or rocking, when such behavior is not normally present, as may be the case with late-stage Alzheimer's disease.
- An elder's report of maltreatment.

Sexual Abuse

- Bruising of the breast or genital area.
- Unexplained venereal disease, genital infection, vaginal or anal bleeding.
- Underwear which is torn or bloody.
- An elder's report of rape or sexual assault.

Neglect (caregiver or self neglect)

- Living conditions which are unsafe or unsanitary, such as lice, fecal or urine smell.
- Inadequate clothing for the conditions.
- Dehydration, malnutrition or untreated health problems.
- An elder's report of mistreatment.
- Homelessness (self-neglect).

Exploitation

- Sudden changes in banking practices
- Withdrawal of large sums of money by elder or person with Power of Attorney.
- Checks made out to "cash."
- Newly formed joint accounts between the elder and another person.
- Strange explanations by the elder as to why money is needed.
- Financial or title transfer transactions using the elder's forged signature.
- Sudden revisions to a will.
- New signatories on the elder's ATM card.
- Transfer of assets to a family member, caregiver or neighbor.
- Unnecessary provision of services.
- Unpaid bills or care not provided despite adequate fund.
- The report of exploitation by the elder.

Abandonment

- Leaving the elder at a hospital, nursing facility, shopping center or other area.
- The report of abandonment by the elder.

Reporting elder abuse

If someone is in a life-threatening situation, call 911 immediately. If you suspect that abuse may be occurring, you can call adult protective services at 888-385-422, the long-term care ombudsman at 866-388-1888, or the general number for the police department in your area.

If you have been the victim of abuse, please tell a trusted friend or family member or your doctor. You can also call the Eldercare Locator help line at 1-800-677-1116, Monday through Friday, 9:00 am to 8:00 pm eastern time. Most states will not require that you identify yourself in order to take the report.

Who are the abusers?

Abusers come from all walks of life. Studies have shown that family members perpetrate the abuse and that adult children are generally more responsible for cases of abuse than are spouses. Anyone who is an abuser of an elder has most likely previously abused others of all ages.

Can elder abuse be prevented?

Educating professionals and the public on the warning signs plays a critical role in helping to stop abuse. Individuals should make an estate plan with an elder law attorney to help protect them and their family. Staying active as much as possible and avoiding isolation is also helpful. Try to visit individuals who are cognitively incapacitated and receiving home or facility care.

What is being done to help stop the problem?

The Elder Justice Act S. 333 was introduced on March 29, 2007 to provide resources to states to help prevent abuse. The Act also proposes to increase prosecution of elder abusers, provide assistance to victims and support for "at risk" older adults. The Elder Justice Coalition is responsible for helping to pass the Elder Justice Act. Log on to www.elderjusticecoalition.com/legislation.htm for more information about the legislation.

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THANK YOU!